CONNECTICUT WOMEN'S HEALTH CAMPAIGN
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Connecticut Women's Health: A Blueprint For The Future

PREVENTION & GENDER COMPETENT SERVICES

Environmental Cause And Mapping Of Breast Cancer

Legislative Proposal To appropriate funding to the state Department of Public Health for the purpose of mapping incidence of breast cancer to determine whether there are any "clusters" in CT that might indicate environmental causes of the disease.

Background: Scientists define "cancer clusters" as places where cancer rates are unusually high or low for reasons other than chance.[i] Breast cancer rates vary by geographical region, suggesting the environment may hold clues to its causes. Most breast cancer research has focused on detection and treatment, with little funding or attention paid to identifying preventable causes. Since research has determined that increased exposure to estrogen over a woman's lifetime increases her risk of breast cancer, scientists are asking whether exposure to chemicals that mimic estrogen might also be linked to breast cancer. Estrogen mimicking chemicals are found in common products like pesticides, detergents and plastics.[ii]

A study published in the *New England Journal of Medicine* found that only approximately 27% of breast cancer risk is attributable to genetic factors. This means that other factors, which may be preventable, are the predominant cause of breast cancer. The article defined "environmental factors" broadly to include pollutants and workplace exposures along with diet, smoking, and other factors.[iii]

Osteoporosis Early Detection And Treatment Referral Program

Legislative Proposal To require the state Department of Public Health to establish an osteoporosis prevention, early detection and treatment referral program to promote prevention, screening detection and treatment of osteoporosis among unserved or underserved populations, to educate the public regarding osteoporosis and the benefits of prevention and early detection and to provide counseling and referral services for treatment. "Unserved or underserved populations" means women who are: (i) at or below two hundred percent of the federal poverty level for individuals; (ii)

without health insurance that covers osteoporosis screening; and (iii) nineteen to sixty-four years of age.

Background:[iv] Osteoporosis is a serious, degenerative bone condition affecting the health of approximately 23 million American women. More than 8 million women have the disease, while over 14 million have osteopenia or "low bone mass" placing them at increased risk of developing osteoporosis. Eighty percent of people with osteoporosis are women. Females experience hip fractures at a rate two to three times higher than males. One in five persons dies within a year of sustaining an osteoporotic hip fracture. A woman's lifetime risk for an osteoporosis-related hip fracture is equal to her risk of breast, uterine and ovarian cancer combined. Between 1993 and 1997, there were 2,827 females discharged from Connecticut acute care hospitals with a primary diagnosis of osteoporosis and 17,046 female discharges that were osteoporosis-related. By 2015, the number of Connecticut females with both osteoporosis and low bone mass is expected to increase by 36 percent, from 316,613 to 429,000.[v]

The anticipated number of individuals with osteoporosis may also be on the rise due to asthma related treatment. About 18 million Americans have asthma and 5 million of them are children.[vi] In 2000, it was estimated that 119,116 Connecticut adults had asthma.[vii] Asthma sufferers may take "long-term-control" medications, e.g. corticosteroids, to relieve their symptoms. Although low and medium dosages of inhaled corticosteroids appear to have no major adverse effects on any clinically important measure of bone metabolism, a dose-dependent, yet significant, reduction in bone mineral contents of subjects with asthma has been associated with inhaled corticosteroid use.[viii]

Osteoporosis is accurately named the "silent disease" because it weakens and thins bones without early warning signs or symptoms. The development of maximum bone strength and density begins in early childhood, and the skeletal bones reach their peak density by about age 30. A woman's risk for osteoporosis increases with the number of her risk factors. Although some of the risk factors are non-modifiable, e.g. being female or early menopause, many are modifiable, e.g. current cigarette smoking, low lifelong calcium intake, low vitamin D intake, low body weight, anorexia, lack of weight-bearing exercise, and long-time use of certain medications. Osteoporosis is highly preventable and treatable, but as of now there is no cure. Prevention efforts are targeted toward two processes in a woman's life: the development of a greater peak bone mass early in life and slowing the rate of bone loss after menopause. Bone mineral density screening exams are relatively quick, painless, and noninvasive tests that can detect, predict, and monitor a person's risk for an osteoporosis fracture.

I. Nutritional Counseling And Therapy

Legislative Proposal To require insurers to provide coverage for medically necessary Medical Nutrition Therapy authorized by a physician for conditions including, but not limited to: hypertension, hypercholesterolemia, hypertriglyceridemia, obesity, morbid obesity, eating disorders, inflammatory bowel disease, gastro-esophageal reflux disease, chronic renal insufficiency, cancer, HIV, unexplained weight loss, malnutrition, malabsorption, prenatal nutrition care, enteral nutrition support and parenteral nutrition support. The patient's physician would authorize the number of visits covered.

Background: Medical Nutrition Therapy (MNT) can be used to treat a wide variety of diseases and conditions and can help reduce the overall cost of health care. Coverage is inconsistent among insurance plans, which results in deferred care, which in turn ultimately increases the cost of health care and increases morbidity and mortality in Connecticut residents. Several medical conditions, which disproportionately affect girls and women such as eating disorders, osteoporosis and pregnancy, are among those for which medical nutrition therapy would be particularly beneficial.

II. School Nutrition

Legislative Proposal To require the state Department of Education to (A) Require all schools to adhere to state regulations regarding the sale of "extra foods" in vending machines, and; (B) create stronger enforcement mechanisms for existing regulations that require schools to shut off vending machines during certain school hours.

Background: The rate of obesity has risen in the nation and has resulted in increases to preventable conditions such as diabetes, cancer, and cardiovascular disease. Over the past decade, schools have made significant strides in improving the nutritional content of meals served in school cafeterias. But those meals are supplemented by an array of alternative sources, such as vending machines, which frequently offer fatty and salty foods that are not as healthy as cafeteria meals. Vending machines are a major impediment to maintaining good eating habits at school.[ix]

Per state board of education regulations, if students have access to vending machines containing "extra foods," the machines must be turned off 30 minutes before and 30 minutes after any state or federally subsidized milk or service program. "Extra foods" are defined as tea, coffee, soft drinks and candy.[x] Only those schools participating in state or federally subsidized food programs must abide the regulation. There are a few districts in the state that do not need to close down their vending machines.

III. Behavioral Health

Legislative Proposal: To require all state funded behavioral health programs to provide gender competent treatment and services.

Background: Gender competent treatment and services are necessary to meet the complex needs of women with behavioral health problems. Women and men have different treatment needs. For women, behavioral health treatment is complicated by the intersecting roles and responsibilities of motherhood and women are more likely to suffer from increased levels of shame, guilt, interpersonal problems, financial difficulty stigmatization, lack of marketable job skills, and social support. In women, mental health problems and histories of sexual or physical abuse frequently co-occur with substance abuse disorders. Violence against women is closely associated with depression and anxiety disorders. Fifty to ninety-five percent of women who have been raped will develop PTSD.[xi] Up to 70% of women in drug abuse treatment report a history of physical and sexual abuse with victimization beginning before 11 years of age and occurring repeatedly.[xii] In addition, women who were sexually abused are significantly more likely to report one or more symptoms of eating disorders than their non-abused peers.[xiii] At least 30% of female trauma patients have been victims of domestic violence.[xiv] Women in recovery from substance abuse are likely to have a history of trauma and are high risk of being diagnosed with posttraumatic stress disorder.[xv] A 1995 Johns Hopkins University School of Medicine survey of nearly 2,000 female patients found that one in three women had experienced domestic violence as an adult or child.[xvi]

For women to succeed in treatment and sustain recovery, behavioral health treatment must address the impact of violence in women's lives and the particular needs of women in treatment. Gender competent services for women address issues that may be barriers to treatment or sustained recovery including childcare, transportation, skills training, and housing. Gender competent treatment addresses women's needs through the development of protocols to address and appropriately respond to clients who disclose sexual assault or domestic violence histories and addresses the client's sexual and domestic violence history while in treatment. Treatment plans also incorporate woman defined advocacy and empowerment models, which address women's experience, strength, and needs.

Women in sustained recovery will be able to maintain employment, care for themselves and their children and be productive members of society. One study shows that one year after treatment 40% of women eliminated or reduced their dependence on welfare.[xvii] Greater collaboration and coordination between agencies and providers will create pathways for comprehensive services and violence prevention and enhance women's abilities to sustain their recoveries and treatment, and thereby reduce the costs to society that are incurred as a result of fragmented, interrupted, and repeated behavioral health treatment services.

Improving The Response To Sexual Assault Victims

Legislative Proposal: To increase funding for rape crisis centers in the Department of Public Health Budget by $250,000 to fund five (5) regional Sexual Assault Response Team Coordinators to establish Sexual Assault Response Teams throughout the State.

Background: A sexual assault response team (SART) is an interagency sexual assault response model based on a team approach. A SART typically includes representatives from a local sexual assault crisis service, the hospital emergency department, the prosecutor's office, and law enforcement agencies. SARTs facilitate a victim-focused, multidisciplinary, coordinated response to sexual assault. This approach prevents secondary victimization[xviii], which exacerbates the negative physical and psychological health effects of sexual assault. A SART may result in increased reporting and prosecution of sexual assault crimes within the community served by the team.

ACCESS TO HEALTH CARE

IV. Health Insurance Expansion

Legislative Proposal Maintain and expand health insurance coverage by: (A) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage for all parents up to 300% of the federal poverty level; (B) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage up to 300% of the federal poverty level for pregnant women for up to two years after a pregnancy; (C) Requiring the state Department of Social Services to apply for a federal waiver to provide insurance coverage for family planning, including STD diagnosis and treatment, for adults up to 300% of the federal poverty level; and (D) Requiring the state Comptroller to allow small business employers to obtain insurance coverage through the Municipal Employees Health Insurance Plan (MEHIP).

Background: There are approximately 253,000 uninsured persons in the state of Connecticut; the rate of uninsured adults is approximately 8.5%. Among those who are uninsured, 11.3% have incomes below 100% of the Federal Poverty Level (FPL); 32% have incomes between 100% and 199% of FPL; 13% have incomes between 200% and 299% of FPL; and a surprising 43.4% have incomes over 300% of the federal poverty level. As many as 70% of those who lack health insurance are working and approximately 15% more are dependent children or spouses of workers; only 15% of the uninsured have no formal attachment to the labor force.[xix] Because of this distribution of uninsured adults and dependents, Connecticut needs a multi-pronged strategy to provide access to health care coverage.

The proposals above would allow Connecticut to expand health insurance coverage to various target populations by utilizing Medicaid funds at a 50% federal reimbursement rate; SCHIP funds at a 65%-90% federal reimbursement rate; and the MEHIP Plan which is not a government subsidized program, but uses the purchasing power of the state to secure affordable health insurance.

For example, since the mid 1990s, states have used Section 1115(a) Medicaid Demonstration waivers to cover family planning services for certain populations. They are attractive because the federal government pays 90% of the costs for services, while the state pays 10%. Most family planning waivers are good for a five-year period**.** Twelve states are currently operating statewide family planning waivers [Arizona, Arkansas, California, Delaware, Florida, Maryland, Missouri, New Mexico, New York, Oregon, Rhode Island, and South Carolina]. Six more states are in the process of applying for a family planning waiver and five additional states are considering it.

V. Gynecological Services For Women With Disabilities

Legislative Proposal To provide women with disabilities equal assess to gynecological services by: (A) Requiring hospitals to develop and summit procedures to the state Department of Public Health regarding their gynecological services for women with disabilities that includes a description of services and accommodations available, and procedures governing confidentiality and consent; (B) Requiring the Department of Mental Retardation (DMR) to develop policies and procedures regarding the use of sedation for gynecological procedures that inform and safeguard DMR female clients. (C) Requiring hospitals and the Department of Mental Retardation to establish a medical review process before someone is sedated for routine exams to determine whether (i) there is absolutely no other alternative to sedation; and (ii) the benefit of the exam outweighs the effects of the sedation and/or procedures; and (iii) the patient has provided informed consent; (D) Requiring hospitals to submit a report, on an annual basis, of its policy regarding the provision of hearing and speech interpretive services; (E) Requiring the state Department of Mental Health and Addiction Services

(DMHAS) to expand it's requirement for yearly physicals to include mammography and pelvic examinations, and; (F) Providing funding for an education and awareness project for consumers and medical professionals, including but not limited to: (i) educating consumers about medical procedures to ensure that consumers have an opportunity to consent to sedation prior to the actual exam; and (ii) educating medical professionals about less invasive alternative procedures and sensitivity to the needs of women with disabilities.

Background: It is common practice for medical professionals to sedate individuals with disabilities when providing routine medical services such as mammograms, dental and pelvic exams. The individual does not always have the opportunity to consent to sedation. Although this is an issue that affects all individuals with disabilities, women are disproportionately affected because they generally undergo several routine gynecological examinations. This practice is often perpetuated for convenience rather than medical necessity, does not provide equal protection to individuals with disabilities, and is often experienced by consumers as physical and mental. Additionally, women with disabilities are not provided gender competent services. For example, the state Department of Mental Health and Addiction Services' policy is to require a yearly physical for its clients. However, the yearly physical does not include procedures that are routine for women, e.g. mammograms and pelvic examinations.

Prescription Drug Coverage

Legislative Proposal: To ensure that consumers have access to reasonably priced prescription drugs by: (A) Establishing a state purchasing system which creates discounted prices for prescription drugs, and (B) Establishing a review board to monitor prescription drug prices.

Background: More than 700,000 state residents are without prescription drug coverage,[xx] while the cost of prescriptions is increasing nationwide at a rate of over 17%.[xxi] Many state programs are being cut due to lack of adequate revenue.

"Women are generally more likely than men to use prescription drugs. Some 40 percent of men and 66 percent of women age 18 to 34 use prescription drugs. Use patterns converge as people get older. Similar proportions of men and women age 65 and older are prescription drug users."[xxii] One must remember, though, that 58% of the over 65 population are females.[xxiii]

Older women are significantly impacted by the rise in prescription drug costs. According to the U.S. Food and Drug Administration, older women take an average of seven different medications at any given time. The majority of older women rely on Medicare coverage that does not cover prescription medications. This lack of prescription coverage translates into a hefty individual bill. According to the Kaiser Foundation the average price per prescription in Connecticut is $52.93.[xxiv] For older, uninsured women taking an average of seven different medications, this translates into $371 a month for out-of-pocket prescription drug expenses.

VI. Patients' Right To Know

Legislative Proposal: To protect all patients' right to know about medical options and to make informed decisions regarding their health and medical care by amending regulations to ensure that no hospital, health care clinic, health care provider, health maintenance organization, insurer, or other entity shall, by contract, bylaw or other means prohibit a physician or other health professional from discussing or recommending any medical treatment or medication that is medically accepted and a reasonable option for a patient's condition or ongoing treatment, regardless of whether the treatment or medication is available at the location at which the patient is treated.

Background: Consumers have the right to receive complete and scientifically accurate information about all medical services and options, including those that are controversial, contrary to some religious beliefs, expensive, or not covered by their insurance. This protection is particularly important to protect consumers' right to know about family planning services, including emergency contraception and abortion.

Midwifery Care

Legislative Proposal: To protect consumer access to professional, out-of-hospital maternity care services and increase the range of quality maternity care choices available to consumers.

Background: While maternity care in the United States has evolved into a $50 billion per year industry, rates of infant mortality, premature birth, low birth weight, induced labor, vacuum extraction, and cesarean section have risen or remained unacceptably high. One response has been for consumers to seek alternatives to standard maternity care practices, including planned, out-of-hospital birth attended by trained midwives. Out-of-hospital birth attended by skilled midwives has been proven to be a safe and cost-effective option for healthy, low-risk mothers. Clinical research has shown midwifery care to be associated with lower rates of cesarean section, lower rates of forceps and vacuum extraction, lower rates of admission to neonatal intensive care units, lower rates of postpartum hemorrhage, higher birth weights, higher Apgar scores, higher rates of breastfeeding, fewer infant deaths, fewer maternal deaths, higher rates of vaginal birth after cesarean, reduced maternity care costs, and greater satisfaction with the birth experience among mothers.

Nationally, approximately 2,000 practicing midwives entered the profession directly through midwifery education and training, rather than through a pre-requisite program such as nursing. This led to the establishment, in the 1990s, of two national certification designations for direct-entry midwives: the Certified Professional Midwife (CPM) and the Certified Midwife (CM). Both the CPM and CM credentials require didactic programs, written examinations, and clinical experience. However, the CPM and CM are distinct credentials conferred by different accrediting bodies and emphasizing different skills.

The full integration of direct-entry midwives into the health care system in Connecticut increases the range of quality maternity care choices available to consumers, increases access to midwives, and introduces the likelihood of improving outcomes for mothers and infants while simultaneously reducing overall maternity care costs.

SUPPORTING COMMUNITY HEALTH

VII. Restore Health Services

Legislative Proposal (A) To restore Medicaid, State Administered Medical Assistance (SAGA), and town General Assistance (GA) medical coverage to include (i) eye care, optical hardware, optometry care, home health care, and (ii) services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists, and (B) To restore SAGA medical transportation.

Background: Per the State budget, Medicaid and State Assistance optional service cuts include services by psychologists, naturopaths, chiropractors, physical, occupational and speech therapists and podiatrists. In addition, home health care and vision, including optical hardware, services have been cut for SAGA. The state Department of Social Services is expecting to implement medical coverage cuts by January 1, 2003.

Expand Community Services

Legislative Proposal To expand services at community health centers and school based health clinics to adequately serve the uninsured.

Background**:** School Based Health Centers, as defined by the Connecticut Department of Public Health, offer comprehensive medical, mental health, and in some cases dental care to the children enrolled in a particular school that has received funding for this purpose. Currently in Connecticut there are 68 schools in 18 communities with School

Based health centers. Included in this number are 22 high schools and 15 middle schools. With 17 years of experience in Connecticut, school based health centers have proven their ability to provide quality health care that is unique because of its accessibility to students. Both preventive and minor acute care services are regularly available.

School based health centers must now bill to third party payors for reimbursable visits and expenses. Though many children receive their primary care services at the school based health center, private insurers have the option of contracting (or not) with them. Parents are not charged co-pays or any out-of-pocket fees. With flat funding from the State of Connecticut, and the inability to bill for reimbursable services, centers are faced with tough choices about staffing and services offered.

Adolescent women are very active consumers of school-based services for their reproductive health care. Pregnancy prevention efforts are vigorous, realizing the high cost of a teen pregnancy both to the teen and to the community at large. Providers have received specialized training in the diagnosis and treatment of sexually transmitted diseases. By state statute adolescents have the right to confidential reproductive health care (although they must have a general parental permission to use the health center). For many students, the school based health center is their only option for getting this confidential care because of the difficulty getting transportation to another facility or having to pay out of pocket for their visit. Both of these barriers are eliminated with SBHC.

Community Health Centers are mandated to go far beyond the provision of traditional medical services. They ensure that people receive comprehensive support services such as: dental care, child care, career counseling, literacy training, referrals to substance abuse providers, transportation, patient education, Healthy Start case management, early education supports, translation services, housing assistance, social service eligibility assistance, mental health, and assistance with HUSKY enrollment. Federally qualified health centers (FQHCs) in Connecticut are losing $1 million annually because of the way the state Department of Social Services (DSS) have calculated their prospective payment rate using 4,200 visit screen per physician FTE which the Federal Courts have found unlawful. As a result of losses from DSS rate setting and cuts to the state Department of Public Health funding to care for the uninsured, health centers will be forced to close service delivery sites, restrict hours, reduce staff, and eventually close their doors altogether. This will leave entire communities without any access to priority and preventive health care services. Over 75% of health center patients have their care paid by Medicaid, Medicare, and other federal grants to care for the uninsured. Health centers cannot compensate for inadequate state resources to the uninsured through Medicaid dollars.[xxv]

VIII. Smoking Prevention And Cessation

Legislative Proposal To appropriate funding to the state Department of Social Services, for the fiscal year ending June 30, 2004, for the purpose of implementing the Department of Social Services' Medicaid state plan to provide smoking cessation services.

Background: Currently, smoking cessation programs and aids are not covered under Medicaid, and many low-income people cannot afford them. According to the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, the average cost per smoker for successful smoking cessation interventions is $165.61. On the other hand, the cost of treatment for smoking related illnesses such as cancer or heart disease can be thousands of dollars. The health costs directly related to tobacco use are exorbitant. In Connecticut, it is estimated that annual "tobacco-caused" health care expenditures total $1.2 million dollars a year, which averages $476 dollars per year per average household.[xxvi] The state and federal tax burden associated with these costs total $589 million a year.

In 2002, the General Assembly passed *PA 02-4, An Act Concerning the Provision of Smoking Cessation Services Under the State Medicaid Plan and Making Technical Corrections to Special Act 01-11 of the November 15 Special Session*, which requires the Commissioner of the state Department of Social Services to amend the Medicaid state plan to provide coverage for treatment for smoking cessation when such treatment is ordered by a licensed health care professional. The Commissioner must present a plan to the Human Services and Appropriations Committees by January 1, 2003. If the committees approve the plan and funding is provided in the budget, the plan will be implemented by July 1, 2003.

IX. Community Support Services For Elders And People With Disabilities

Legislative Proposal: To provide community support services for elders and people with disabilities by: (A) Maintaining open enrollment to the Connecticut Home Care Program for Elders for all eligible clients; (B) Amending the income eligibility for Levels One and Two of the Connecticut Home Care Program for elders to match the ConnPACE Program of $20,000 per individual and $27,000 per couple; (C) Increasing the care plan limits for formal services by raising the current formulary in each category to more closely approximate the costs of nursing home care. Any additional costs to the program would be offset by the delay and prevention of nursing home placement; (D) Opposing efforts to change the rules concerning the transfer of assets for Medicaid eligibility; (E) Requiring the state Department of Social Services to provide personal care assistance services under the Independence Plus Waiver to the same extent and beyond that such services are provided in the personal care assistance waiver pursuant to section 17b-262-58 of the Connecticut General Statutes; (F) Appropriating the sum of $500,000 annually to the state Department of Social Services for the purpose of funding the Center for Medicare Advocacy; (G) Appropriating the sum of $100,000 annually to the state Department of Social Services for the purpose of funding the CHOICES Program to improve consumer access to information and services that provide a range of community resource topics including Medicare, Medicaid and Medigap, and; (H) Requiring the state Department of Social Services to establish and administer a transition assistance program, which shall provide transition services to individuals who reside in a long term care facility, are Medicaid eligible and many appropriately return to the community. Transition services shall include but not be limited to care management, personal care services, security deposits, furnishings, and any other services.

Background: In Connecticut as well as nationwide there is a growing population of elders who will increasingly rely on services that help them remain independent and in their communities. The fastest growing cohorts of this population are individuals 85 plus and female. The 2000 Census shows that 46,341 women age 85 and over resided in Connecticut. This number is projected to increase by nearly a third in the year 2010 to 72,515.

The number of people with disabilities also continues to grow and with this growth is a burgeoning movement by those with physical and psychiatric disabilities to remain independent through self-directed care. According to the latest US census 19% of all people have disabilities. People with disabilities are often dually eligible for Medicare and Medicaid.

The U. S. Supreme Court ruling in Olmstead v. L. C., 119 S. Ct. 2176 (1999) mandates that services be available to meet the needs of such persons wishing to live in the community. Older women and non-elders with disabilities wish to remain in a community setting. Not only because the cost effectiveness of this choice is clear, but it is the "right thing to do." Older women and non-elders with disabilities are able to remain in a community setting because of the following community support services:

- The Connecticut Home Care Program for Elders - a responsive system of care management and provision of necessary services, which currently has 12,000 active participants.
- The Center for Medicare Advocacy - provides excellent education and advocacy to Medicare beneficiaries throughout the state of Connecticut.
- The Connecticut's Program for Health Insurance Assistance, Outreach, Information and Assistance, Counseling and Eligibility Screening Program (CHOICES) - provides valuable information to older adults via an information and referral program operated by the Area Agencies on Aging.
- Additionally, Connecticut currently has five home and community based waivers that serve a limited number of people with specific disabilities of particular age groups.

X. Biennial Report On The Health Status Of Women

Legislative Proposal To provide data analysis and education about the health status of women by: (A) Funding the Permanent Commission on the Status of Women (PCSW) to prepare a biennial report; and (B) Preparing a biennial report

to provide information regarding breast and ovarian cancer, domestic violence, sexual assault, and the link between smoking, weight loss and obesity, HIV/AIDS, depression, adolescent health, emergency contraception, and access to services by women with disabilities.

Background[xxvii]: During the last century, factors such as improvements in medical technology, environmental controls, social legislation and personal lifestyle changes have increased a woman's life expectancy dramatically – from 48 years for a woman born in 1900 to 80 years for a woman born in 1998. Because the reproductive years now constitute less than half of a woman's life expectancy, the definition of women's health has broadened beyond reproductive health to consider social issues, chronic conditions, infectious diseases, and injury and violence that affect women throughout their lives. It is essential to begin to track the conditions that are unique to or more prevalent in females, and report this information to state residents.

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[ii] Fact Sheet, Silent Spring Institute, Newton, MA
[iii] *New England Journal of Medicine*, 2000, 343:78-85.
[iv] Source unless otherwise indicated - CT Department of Public Health, *Connecticut Women's Health, 2001*, Chapter 17.
[v] CT Department of Public Health, *Connecticut Women's Health, 2001*, Chapter 17.
[vi] Centers for Disease Control and Prevention, National Center for Health Statistics, available at www.cdc.gov/nchs/fastats/asthma.htm.
[vii] Behavioral Risk Factor Surveillance Survey, CDC, 2000.
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[ix] John A. MacDonald. "Fitness Scores Failing: Children Pay Price for Food Choices, Academics Emphasis," *The Hartford Courant*, 10/8/02, page A5.
[x] State Board of Education Regulations §§ 10-215b-1(b).
[xi] Johns Hopkins School of Public Health (2000)
[xii] National Institute on Drug Abuse (1998)
[xiii] Laws & Golding (1996)
[xiv] Substance Abuse Treatment and Domestic Violence, Substance Abuse and Mental Health Administration (2000)
[xv] Substance Abuse Treatment and Domestic Violence, Substance Abuse and Mental Health Administration (2000)
[xvi] National Resource Center on Domestic Violence (1997)
[xvii] Substance Abuse in Brief, Center for Substance Abuse Treatment (January, 1999)
[xviii] Secondary victimization is defined as the victim-blaming attitudes, behaviors, and practices engaged in by medical, police, and legal systems personnel, which further the rape event, resulting in additional trauma for the survivor. (See, e.g. Campbell R.& Raja, S. (1999))
[xix] Lewin Group Analysis of Current Population Survey, U.S. Census, March 2002 Supplement, prepared for the Connecticut Health Advancement and Research Trust (CHART).
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[xxv] "The Impact of Reduced DPH Funding for Services to the Uninsured in Connecticut," fact sheet, Connecticut Primary Care Association, September 2002.
[xxvi] Campaign for Tobacco-Free Kids, *Tobacco-Caused Health Care Expenditures in Each State and Related Federal-State Tax Burdens on Each State's Citizens* (October 25, 2001) available at http://tobaccofreekids.org.
[xxvii] CT Department of Public Health, *Connecticut Women's Health, 2001*, Introduction.